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In The
Supreme Court of the United States

JOHN D. ASHCROFT,
Attorney General, et al.,

Petitioners,

v.

ANGEL MCCLARY RAICH, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF *AMICUS CURIAE* OF REASON FOUNDATION IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Does the Controlled Substances Act, 21 U.S.C. § 801, *et seq.*, exceed Congress' power under the Commerce Clause as applied to the intrastate cultivation and possession of marijuana for purported personal "medicinal" use or to the distribution of marijuana without charge for such use?

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INTEREST OF *AMICUS CURIAE*

Pursuant to Supreme Court Rule 37, Reason Foundation respectfully submits this brief *amicus curiae* in support of respondents on the merits.[1]

Amicus Curiae Reason Foundation is a national research and educational organization. Reason Foundation advances the ideas of individual liberty, free markets, and the rule of law. Reason Foundation uses journalism and public policy research to influence the frameworks and actions of journalists, policymakers, and opinion leaders.

The world leader in privatization, Reason Foundation is known for practical and innovative public policy ideas that emphasize competition, transparency, and accountability for results. Reason Foundation conducts research on the role of choice, local knowledge, and a dynamic market economy in human progress. Reason Foundation has participated as *Amicus Curiae* in significant cases involving individual rights and the rule of law, including *Gratz v. Bollinger*, 539 U.S. 244 (2003) and *Grutter v. Bollinger*, 539 U.S. 306 (2003).

Reason Foundation publishes *Reason* magazine, which has a circulation of 55,000. *Reason*, the magazine of Free Minds and Free Markets, covers politics, culture, and ideas.

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[1] Pursuant to Supreme Court Rule 37.6, *Amicus Curiae* affirms that no counsel for any party authored any part of this brief and no person or entity made a monetary contribution for the preparation or submission of this brief. Respondents have consented to the filing of this brief. The parties have provided written consent to the filing of this brief.

Reason Foundation is an Internal Revenue Code section 501(c)(3) nonprofit corporation incorporated in 1978 and funded by private, voluntary contributions.

SUMMARY OF ARGUMENT

Petitioners argue that the intrastate cultivation and possession of medical cannabis for personal, medicinal use by respondents, and those similarly situated, has a substantial affect on interstate commerce in marijuana.[2] Minimal empirical evidence is cited by petitioner to support their argument, and it appears unlikely that their conclusion can be substantiated. The Congressional findings referenced by petitioners do not take into account the affect of existing California law which continues to substantially prevent cannabis from being diverted into the commercial market.

Both California and federal law prohibit commerce in marijuana. California state law prohibits personal use and possession of marijuana, unless the person in possession can prove that they have an illness for which cannabis provides relief.

California does not enforce the federal prohibition on medicinal use of cannabis, which is its prerogative under our federal system. However, existing California law prohibits cannabis used for medicinal purposes from entering the commercial market. Cannabis cultivation is

[2] Federal law defines marijuana as "all parts of the plant Cannabis sativa L" with certain exceptions. 21 U.S.C. § 802(16). In this brief, the term "cannabis" refers to any part of the plant cannabis used for medical purposes.

limited to that which is necessary to satisfy the needs of cannabis patients. Patients can use cannabis for medicinal purposes only with the approval or recommendation of a physician. Physicians may only recommend or approve cannabis for illnesses for which cannabis provides relief. Physicians that falsely or fraudulently recommend or approve medical cannabis may have their licenses revoked. Physicians have been investigated and had their licenses suspended for such recommendations. The amount a qualified patient or their caregiver may possess is limited to that which is necessary to satisfy the patient's needs, and any patient or caregiver that puts cannabis into the stream of commerce remains subject to existing California and federal laws prohibiting sale. Therefore personal cultivation and possession of cannabis for medicinal purposes is unlikely to have a substantial affect on the interstate market for marijuana. Should circumstances change, the federal government no doubt would retain the right to prosecute such entry.

In the face of existing California law, there is scant evidence that federal law is necessary to prevent entry of cannabis into the illicit interstate market for recreational marijuana. Congress' findings in the Controlled Substances Act, 21 U.S.C. § 801 (1970) ("CSA") do not address the affect of tightly regulated, noncommercial possession of cannabis for medicinal purposes. Nor do they demonstrate that mere possession of cannabis for medicinal purposes has a substantial affect on interstate commerce – particularly where those in possession have a medical need for cannabis and their health and freedom would be jeopardized by letting their allotment enter the interstate market. Therefore, Congress' findings should be

disregarded as to the respondents and those similarly situated.

ARGUMENT

I. The Evolution of California's Medical Cannabis Law

As with federal law, California law generally prohibits the cultivation, possession, sale, and transportation of marijuana. Every person who transports, imports in-state, sells, furnishes, administers, or gives away any marijuana is guilty of a felony. Cal. Health & Safety Code § 11360(a). Possession and cultivation of marijuana are prohibited. *Id.* §§ 11357, 11358. Possession with intent to sell is a felony. *Id.* § 11359. Proof of possession with intent to sell may be circumstantial, and may consist of evidence as to the quantity of the narcotic, the manner of packaging, and the opinion of an expert that the marijuana was being held for sale. *People v. De La Torre*, 268 Cal. App. 2d 122, 126 (1968). It is a crime to maintain any place for the purpose of unlawfully selling, giving away, or using marijuana. *Id.* § 11366.

In 1996, California voters passed Proposition 215, which excepted qualified patients[3] and their designated caregivers from state prosecution for possession or cultivation of cannabis for the personal medicinal purposes of the Qualified Patient, upon recommendation or approval by a physician. *See* Cal. Health & Safety Code § 11362.5(d)-(e).

[3] Patients that are qualified to use cannabis medicinally under California law are referred to throughout this brief as "Qualified Patients."

This Proposition was enacted as the "Compassionate Use Act." *Id.* § 11362.5(a).

In 2004, Senate Bill 420 ("SB 420") (enacted as the "Medical Marijuana Program") was enacted into law. This act clarified the limits of cannabis which Qualified Patients could possess. *See id.* § 11362.77. Under SB 420, transportation, use of buildings and nonprofit sale of cannabis are not prohibited under California law. *Id.* § 11362.765(a).

The Medical Marijuana Program also provides for medical identification cards for Qualified Patients and their caregivers. These cards incorporate security measures similar to driver's licenses. *See id.* §§ 11362.72, 11362.735. The Program implemented a statewide registry of cardholders. *Id.* §§ 11362.715, 11362.72, 11362.74, 11362.745, 11362.76. Cannabis may not be used medically (or otherwise) at work, while operating a car or boat, within the vicinity of a school, or anywhere where anti-smoking laws apply. *Id.* §§ 11362.785, 11362.789.

The Medical Marijuana Program also provides for the creation of a state-sponsored research program to develop medical guidelines for the appropriate administration and use of cannabis. *See id.* § 11362.9(a)(2).

II. Petitioner Has Provided No Evidence that California Law Does Not Effectively Prevent Medical Cannabis Cultivation from Having a Substantial Affect on the Commercial Market for Recreational Marijuana

Proposition 215 exempted medical use of cannabis from state prosecution for cultivation and possession. In the eight years since the passage of Proposition 215,

California statutory and judicial law has clarified the scope of the medical exemption to state laws prohibiting cannabis. California has proscribed the conditions under which cannabis may be possessed. Patients must prove their medical need. Physicians cannot recommend cannabis unless it can be shown to treat illness. State mandated ceilings limit the amounts which patients and their caregivers may possess. Doctors that recommend cannabis have such recommendations scrutinized by the California Medical Board. Sale remains prohibited under California and federal law.

This legal regime effectively precludes cannabis from entering the interstate black market for recreational marijuana. Although individual instances of diversion of cannabis to illicit purposes undoubtedly occur, there is no evidence that cultivation of cannabis has had a "substantial affect" on the black market for recreational marijuana.

The Court need not take *Amicus* at their word. California has recently had record marijuana busts. The federal government's own studies reflect that abuse of the medical cannabis system has not resulted in routine diversion of cannabis for recreational or commercial purposes. *Tellingly, the federal government has not provided evidence that medical cannabis has had any impact on the commercial market for marijuana, let alone a substantial one.* Whether particular operations affect interstate commerce sufficiently to come under the constitutional power of Congress to regulate them is ultimately a judicial rather than a legislative question. *United States v. Morrison*, 529 U.S. 598, 614 (2000). The existing California regulatory framework is a key factor in any determination of whether intrastate cultivation and possession

has a substantial affect on the illicit, interstate market for marijuana.

Amicus does not argue that a comprehensive regime of state law regulation can divest Congress of its authority to regulate interstate commerce. However, it is now a firmly rooted constitutional principle that unless regulation concerns the channels or instrumentalities of commerce, an activity must have a "substantial affect" on interstate commerce in order to subject it to Congressional regulation under the Commerce Clause. *United States v. Lopez*, 514 U.S. 549, 558 (1995), *Morrison*, 529 U.S. at 609. Speaking purely as a descriptive matter, the State of California has adopted a system of regulation that meaningfully prevents medical cannabis from entering the commercial market for marijuana.

A. Patient and Caregiver Access Is Limited by Medical Approval

California has established a comprehensive system of controls that effectively keeps cannabis from entering the black market for recreational use. Doctors, Qualifying Patients, and the patients' caregivers are all regulated in an effort to prevent use of cannabis for anything other than medicinal purposes. Further, sick patients remain subject to state and federal criminal prosecution should their cannabis enter the recreational market.

Under California law, a Qualified Patient may use cannabis only for medicinal purposes upon a physician's approval or recommendation. Cal. Health & Safety Code § 11362.5(d). Before a patient is qualified, they must have cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or another illness for which cannabis

provides relief. *Id.* § 11362.5(b)(1)(A). A physician's approval or recommendation must be obtained before use occurs. California courts do not allow a physician's recommendation or approval to be made after use, unless a defendant can show that he used cannabis under "exigent circumstances." *People v. Rigo*, 69 Cal. App. 4th 409, 412-13 (1999) (finding no exigent circumstances).[4]

The requirement that patients have a demonstrated need for treatment acts as a means to monitor physicians as well as patients. The Medical Board of California has issued guidelines which provide that cannabis recommendations should be based on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of medical cannabis is as good, or better, than other medications that could be used for that individual patient. (Medical Board of California, "California Physicians and Medical Marijuana" (last visited October 12, 2004) <http://www.medbd.ca.gov/Guidelines_Marijuana.htm>). Physicians that recommend cannabis without a valid basis are sanctione by the Medical Board. *People v. Spark*, 121 Cal. App. 4th 259, 263 (2004) (Testifying physician admitted that he was no longer licensed to practice medicine at the time of trial. His license had been suspended for giving medical cannabis recommendations to four

[4] There are no reported cases in which "exigent circumstances" allowed post-use recommendation or approval under the Compassionate Use Act. Further, Lexis and Westlaw searches fail to reveal any nonreported cases in which exigent circumstances allowed post-use recommendation or approval.

undercover police officers). *See also Bearman v. Superior Court*, 117 Cal. App. 4th 463, 468-69 (2004) (medical cannabis patient's records can be subpoenaed in investigation by state medical board where good cause is shown). Therefore, the possibility of losing their medical license operates as a strong disincentive for physicians to fraudulently recommend cannabis for nonmedicinal purposes.

Someone cannot be the primary caregiver without being designated by a Qualified Patient. Cal. Health & Safety Code § 11362.5(d). In order to be a caregiver, a person must consistently assume responsibility for the housing, health, or safety of the Qualified Patient. *Id. See People v. Peron*, 59 Cal. App. 4th 1383, 1395 (1997). A person cannot functionally be a "primary caregiver" to a large number of people, they must have an ongoing personal relationship with the Qualified Patient. *See, Peron* at 1395-98.

Under California law, sick people can obtain medical cannabis only pursuant to a physician's recommendation. Caregivers must prove that their patient is qualified and that they have an ongoing relationship of care for that patient. The physician must provide a *bona fide* recommendation or face possible suspension of their license and criminal prosecution. Patients and their caregivers face criminal liability if they misappropriate medical cannabis for illicit purposes. Under these conditions, it is unlikely that the status of a physician, patient or caregiver would readily provide sufficient cover for an opportunistic participant in the commercial market.

B. Law Enforcement Retains Meaningful Constraints on Medical Cannabis Users Which Restrict Entry into the Illicit Market

Throughout California's experience with medical cannabis, law enforcement has consistently kept medical cannabis distinct from the illicit market for recreational use of marijuana. Marijuana does remain the same substance no matter whether it is used for medicinal or recreational purposes. However, from an enforcement perspective the purpose for which marijuana is used serves as a useful means of preventing it from entering the illicit market and having a substantial affect on interstate commerce.

Persons in possession of cannabis cannot retain possession unless such person verifies that the purpose of possession is for medicinal use. The Compassionate Use Act does not purport to provide medical cannabis patients with a right to possess cannabis. Rather, when a patient is arrested for possession of medical cannabis, the patient can seek to prove that the use is medicinal as an affirmative defense at trial. *People v. Trippet*, 56 Cal. App. 4th 1532, 1546 (1997), *People v. Mower*, 28 Cal. 4th 457, 469 (2002). Thus, where law enforcement officers or agencies believe that medical cannabis is being diverted for recreational purposes, they may seize the same, thereby preventing its entry into the market.

The California legislature recently authorized the creation of a statewide registry for state medical cannabis identification cards. Where a Qualified Patient or their caregiver in possession of statutorily limited amounts of cannabis presents this card to a state law enforcement officer, the patient or caregiver can avoid arrest, unless there is reasonable cause to believe that the information

contained in the card is false or falsified, that the card has been obtained by means of fraud, or the person is otherwise in violation of the law. Cal. Health & Safety Code § 11362.71(e). The identification cards for Qualified Patients will be readily distinguishable from the identification cards for caregivers. *Id.* § 11362.71(d)(3).

Though not yet implemented, the system will greatly increase law enforcement's ability to isolate and apprehend abusers of the medical cannabis exception. The registry will enable state and local law enforcement to verify identification card validity through a 24-hour database accessible through a 1-800 telephone number. *See id.* § 11362.71(a)(2). The database will be compiled from the counties' health departments, which first obtain the data by verifying individual patients' applications for identification cards. *See id.* § 11362(b).

To obtain an identification card, a patient must provide copies of medical records, created by the patient's attending physician. The application must reflect that the patient has a serious medical condition for which the physician deemed cannabis "appropriate." The attending physician must be identified by name, office address, office telephone number, and California medical license number; proof of residency within the issuing county; and a "government-issued photo identification card." *See id.* §§ 11362.7(i), 11362.715(a). The name and duties of their primary caregiver must also be provided. *Id.* § 11362.715(a)(4). Before it may issue an identification card, a county health department must verify that all information in the application is accurate. Also, it must verify that the attending physician has a license to practice in good standing. The county must contact the physician to verify the legitimacy of the medical records

submitted in the application. *Id.* § 11362.72(a)(1)-(a)(3). If the county issues an identification card, it must within 24 hours electronically transmit the identification card holder's information to the state department of health services. *Id.* § 11362.72(b).

The identification cards have the security provisions typically found in a government-issued identification card. Each card has a unique user identification number, the name and telephone number of the county health department, and the toll-free telephone number that State and local law enforcement officers can call at any time to obtain "immediate access" cardholder information. Each card must carry a photo identification of the patient or caregiver. *Id.* § 11362.735. All cards have an expiration date. Identification cards are valid for one year only, and the county health department must verify all of a patient's new information before it can renew the patient's Identification card. *Id.* § 11362.745(a). The county also may verify any other information that has not changed. *Id.* § 11362.745(b).

The person who possesses an identification card shall notify the county of any change in the Qualified Patient's attending physician or designated primary caregiver. *Id.* § 11362.76(a)(1). They must also annually submit written documentation of the person's serious health condition and the name and duties of the primary caregiver for the forthcoming year. *Id.* § 11362.76(a)(2). Failure to provide this information will result in expiration of the identification card. *Id.* § 11362.76(b).

California law provides strict prohibitions on attempts to fraudulently obtain or manipulate identification cards. Under the California Health and Safety Code, fine and

imprisonment can result for anyone who fraudulently represents a medical condition or fraudulently provides any material misinformation to a physician, county health department or the county's designee, or state or local law enforcement, for the purpose of falsely obtaining an identification card. *Id.* § 11362.81(a), (b)(1). The same punishment will be imposed on anyone who steals or fraudulently uses an identification card (*id.* § 11362.81(b)(2)) or who counterfeits, tampers with, or fraudulently produces an identification card (*id.* § 11362.81(b)(3)). Should a person engage in any of these activities, they may be precluded from attempting to obtain an identification card for six months. *Id.* § 11362.81(c). In addition, the Attorney General is charged with developing appropriate guidelines to ensure the security and nondiversion of cannabis grown for medicinal use by Qualified Patients. *Id.* § 11362.81.

Some California counties have already met with success in using identification cards to efficiently ascertain whether a person in possession of marijuana is a Qualified Patient. One county found that law enforcement resources are effectively conserved by readily drawing the distinction between Qualified Patients and those in possession for recreational purposes. (Mendocino County Sheriff's Office, *Medical Marijuana: Implementing Proposition 215*, <http://www.co.mendocino.ca.us/sheriff/Prop215.htm.>) Once the statewide registry is in place, California can expect even greater efficiency from law enforcement in separating Qualified Patients from fraudulent abusers of the system.

A study performed by the federal government suggests that federal law enforcement officers have not had their enforcement efforts impeded by diversion of medical marijuana, either. During review of federal law enforcement officers in a 2002 United States General Accounting

Office ("GAO") study, none of the federal officials the GAO interviewed provided information to support a statement that abuse of medical marijuana laws was routinely occurring in California. General Accounting Office, *Marijuana: Early Experiences with California's Laws that Allow Use for Medical Purposes* 37 (Nov. 2002). Were federal law enforcement efforts impeded by diversion, one might expect that the federal approach to enforcement would have changed in the eight years since Proposition 215 passed. However, federal law enforcement efforts have not substantially changed since California law enforcement ceased to prohibit medical marijuana. *Id.* at 32 (finding that introduction of medical cannabis laws had little impact on law enforcement officers operations and that the federal process of using case-by-case review of potential marijuana prosecutions has not changed as a consequence of state marijuana laws).

C. Patient and Caregiver Possession Restrictions Limit the Amount of Medical Cannabis Which Might Otherwise "Substantially Affect" the Interstate Market

Since California authorities ceased to prohibit cannabis for medical purposes, the state has limited the amount of cannabis Qualified Patients can possess to what is necessary for their treatment. Soon after Proposition 215 passed, a California Court of Appeal held that the quantity possessed by the patient or the primary caregiver, and the form and manner in which it was possessed, was limited to what was reasonably related to the patient's current medical needs. *Trippet* at 56 Cal. App. 4th 1549. This determination would be made by a judge or jury, as appropriate, but a significant piece of evidence in making this

determination would regularly be the recommending or approving physician's opinion regarding the frequency and amount of the dosage the patient needs. *Id.* at 1549.

The California legislature subsequently added greater clarity to the issue of amount. Upon passage of SB 420, a Qualified Patient or primary caregiver is entitled to possess no more than eight ounces of dried cannabis per Qualified Patient, and (to assure future supply), the patient or his or her caregiver may maintain no more than six mature or 12 immature plants per Qualified Patient. Cal. Health & Safety Code § 11362.77(a). By comparison, the federal government's "Compassionate Use Program," which provides cannabis to a handful of patients pursuant to an out-phased research program, has provided its patients with up to eleven cured ounces of cannabis every three weeks.[5]

A patient may possess no more than the statutory limits at any time, unless an exception applies. The Qualified Patient or caregiver can possess more than this amount only upon recommendation by a physician or upon countywide approval for greater limits. Further, the California Attorney General may, after public comment, recommend greater limits based on currently available scientific research.[6]

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[5] *See, e.g.*, Letter from Irvin Rosenfeld, federal medical cannabis patient, to whom it may concern (July 1, 1996) (on file with Reason Foundation) (11 ounces every three weeks); Letter from Barbara Douglas, federal medical cannabis patient, to whom it may concern (July 1, 1996) (on file with Reason Foundation) (nine ounces per month).

[6] If the patient needs more than the amount allowed under Cal. Health and Safety Code § 11362.77(a), then they must receive a doctor's

(Continued on following page)

Such restrictions assure that patients only receive the amount of cannabis they need to treat their ailments. Petitioners argue in their Brief that Qualified Patients can be expected to commonly divert cannabis they use as medicine to the illicit market, stating "Local users may ultimately sell or divert the drug to others . . . " (Brief at 25). However, this does not comport with self-interest of Qualified Patients or those persons such patients have chosen as their caregivers. Qualified Patients cannot be expected to routinely divert their medication in expectation of compensation. If they do, they will suffer their illness for lack of proper treatment.

Moreover, irrespective of the outcome of this case, California and federal law will both continue to prohibit sale of marijuana for recreational purposes. The Qualified Patients or caregivers will face the same state and federal criminal penalties should they put medical cannabis in the recreational market. Whether they possess a state-issued identification card or not, the accused will have to prove as an affirmative defense that the medical cannabis defense applies. *People v. Konow*, 32 Cal. 4th 995, 1003 (2004). (For-profit sale of marijuana remains prohibited under state law), *Mower*, 28 Cal. 4th at 469 (Compassionate Use Act does not provide a "complete immunity"

recommendation for the same. *Id.* § 11362.77(b). Also, in order to allow for geographical variances in production capacity, SB 420 provides that cities and counties may promulgate their own regulations allowing patients or qualified caregivers to exceed the state limits set forth in section 11362.77(c). The California Attorney General may also recommend modifications to the Legislature by December, 2005. Cal. Health & Safety Code § 11362.77(e).

whereby claimed patient can compel further investigation merely by claiming that he is a Qualified Patient.)[7]

Were a cannabis patient tempted to sell "excess" medical cannabis on the recreational market, they would encounter existing legal prohibitions under California and federal law.[8] Qualified Patients face the same criminal prohibitions as any other Californian should they exceed the amounts they may lawfully possess or transfer cannabis to a person other than a patient or caregiver. Cal. Health & Safety Code §§ 11362.77(a), 11357, 11359. Of course, once marijuana entered the stream of interstate commerce, patients or their caregivers would also be subject to prosecution under federal law. The same holds true for caregivers that possess or transfer cannabis to persons other than patients or caregivers. *Id.* These prohibitions make it doubtful that possession or cultivation of cannabis for medicinal purposes will have a substantial affect on interstate commerce for marijuana.

The foregoing legal structure does not provide a mere theoretical prohibition regarding commercial demand for medical marijuana. Rather, the theory behind Proposition 215 has been borne out in practice. California state law

[7] As noted above, persons who fraudulently attempt to or use, seek or tamper with identification cards may also be precluded from applying for the same. Cal. Health & Safety Code § 11362.81(c).

[8] Although California authorities will not assist federal authorities in preventing Qualified Patients from using marijuana, California law does not purport or threaten to supersede federal authority. For instance, if a small amount of marijuana were seized en route from Mexico or Las Vegas to San Diego, and the person in possession claimed a defense under California's Compassionate Use Law, there would be no question that interstate commerce occurred. California's law would neither purport to nor actually provide a defense to such person.

enforcement has an established track record of policing sales of illicit marijuana. In fact, the California Attorney General recently announced record-breaking seizures of "large-scale illegal marijuana grows." Office of the Attorney General, *Campaign Against Marijuana Planting Achieves Milestone for 2004 Eradication Season* (last visited October 12, 2004), *available at* http://ag.ca.gov/newsalerts/2004/04-103.htm. The Attorney General announced seizures in 2004 of a total of 471,128 plants worth an estimated $1.88 billion. This announcement was made on September 9, 2004 and therefore did not include plant seizures that will occur from September 10, 2004 through December 31, 2004. Yet the state had already surpassed its record of 466,054 plants seized in 2003 – which was also a record-breaking year. *Id.* Given this track record, it is unreasonable to assume that a trickle of diverted medical cannabis will affect the interstate illicit market.

III. The Congressional Findings in the Controlled Substances Act Should Not Be Given More than Minimal Weight in Determining Whether Respondents' Conduct Has a "Substantial Affect" on Interstate Commerce

Petitioners claim that the cultivation and possession of cannabis for medicinal purposes by respondents and those similarly situated has a substantial affect on the interstate market for marijuana. In support of this claim, they reference the Congressional findings in the CSA that provide, among other things:

> 1. After manufacture, many controlled substances are transported in interstate commerce (21 U.S.C. § 801(3)),

> 2. Local distribution and possession of controlled substances contribute to swelling the interstate traffic in such substances (21 U.S.C. § 801(4)), and
>
> 3. Controlled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate, and thus it is not feasible to distinguish between such substances in terms of controls. (21 U.S.C. § 801(5)).

(Pet'rs. Brief at pp. 4-5).

Based on these findings, Petitioners argue that allowing possession and cultivation by Qualified Patients and their caretakers within California necessarily will have a substantial impact on the interstate market for marijuana. They argue that from an enforcement perspective, all marijuana is the same, whether it is used recreationally or medicinally. Medical cannabis is fungible and can therefore meet illicit demand. Therefore, they argue that all use must be deemed commercial to allow for effective regulation. ("Moreover . . . respondents' manufacturing, distribution and possession activities themselves involved economic activity . . . to at least the same extent as Roscoe Filburn's home-grown production of wheat in *Wickard*. In both cases, the regulated individuals are producing a fungible commodity for which there is an established market and are doing so for their own use when they would otherwise be participants in a regulated market.") (Pet'rs. Brief at 37).

This analysis fails to take into account California and federal law which act as a barrier for medical cannabis to enter into the illicit market.

As set forth above, the class of people that can possess cannabis for medical purposes is limited. To obtain Qualified Patient status under California law, a person must have an illness for which cannabis provides relief, and receive the recommendation or approval of a physician. The physicians who evaluate the patient run the risk of losing their license should they provide a fraudulent recommendation. Caregivers must prove that they have been designated as primary caregivers by an identified Qualified Patient, and they must prove that they have consistently assumed responsibility for the housing, health or safety of that person. The "Qualified Patient" and "caregiver" classifications narrow who may possess or cultivate cannabis to an identifiable class of persons. Where the persons who can legally possess cannabis are ascertainable by reference to a medically verifiable standard, the chance of successful false claims of status is minimized. Therefore, possession for medicinal as opposed to recreational purposes is ascertainable from an enforcement perspective.

Just as certain amounts have always been deemed presumptive of an intent to sell, the limits on possession established by California law also act as an indicator of whether cannabis is used for medicinal or recreational purposes. Neither Qualified Patients nor their caretakers can possess an amount of cannabis in excess of that allowed under state law. The limits under California state law operate as a bright line separating a sick person or their caretaker from a drug dealer. The limits on possession therefore act as an additional guarantor that those who can prove Qualified Patient or caretaker status do not abuse such status and begin selling marijuana. Because the state limits indicate if someone is abusing their status,

the limits reinforce the difference between cannabis and recreational marijuana for enforcement purposes.

Petitioners further argue that Qualified Patients and their caregivers can be expected to divert cannabis to the illicit market in such frequency that it would result in a substantial affect on the interstate market. ("The 'home-grown' manufacturing, free distribution, and possession of controlled substances ... pose an appreciable risk of diversion to others (for instance, should their production yield exceed their purported needs or should additional funds be required to finance their drug production or other activities).") (Pet'rs. Brief, pp. 25-26). But this speculative inference from the Congressional findings about "swelling" of the interstate market for marijuana is wholly unsubstantiated.

California law limits the amount of cannabis Qualified Patients may possess. Qualified Patients would risk their health if they attempted to divert cannabis. With the amount of cannabis patients may possess limited to their needs, patients would choose remuneration over their own health should they divert their cannabis. While this may occur in some instances, it is not likely that it would occur with sufficient frequency to affect the interstate market. Further, even more severe risks to the patient's health can occur should they divert medical cannabis. They may be deprived of treatment while awaiting trial in an attempt to prove the affirmative defense of medicinal use.

Of course, California state law does not purport to change federal law prohibiting sale. Because illicit sales remain unlawful under state law, Qualified Patients and their caregivers also risk their liberty should they attempt to divert medical cannabis into the illicit market.

Moreover, respondents do not contend that they have a right to buy or sell marijuana. They and those similarly situated with them simply wish to cultivate it for personal, medicinal use.

Petitioners' cited Congressional findings simply do not substantiate the inferences they draw. Where only a distinct, identifiable class of persons can possess a limited amount of cannabis, and certain amounts indicate that possession is not for medicinal use, then cannabis is distinguishable from recreational marijuana for enforcement purposes. Where patients risk their health and freedom by diverting cannabis, they cannot in the absence of credible evidence lightly be presumed to frequently engage in that course of conduct.

The existence of Congressional findings is not by itself sufficient to sustain the constitutionality of Commerce Clause legislation. *United States v. Morrison*, 529 U.S. at 614. The judiciary ultimately determines whether particular operations affect interstate commerce sufficiently to come under the constitutional power of Congress to regulate them. *Morrison* at 614. Ultimately, it is the government which carries the burden of establishing that a party's conduct has an affect on interstate commerce. *United States v. Farmer*, 924 F.2d 647, 651 (7th Cir. 1991). (RICO case). The government has not met this burden.

Petitioners rely on Congressional findings which claim that cannabis use is indistinguishable from recreational use. California law suggests otherwise. In California, patients are identified using objective medical criterion that is evaluated by the California Medical Board. Possession of a suspicious amount by a nonpatient or caregiver serves as indicia that nonmedical use is occurring.

Similarly, Petitioners have not provided any evidence that respondents, or anyone similarly situated to them, have diverted their cannabis into commerce. They have not presented any evidence that diversion occurs in an amount sufficient to have a substantial affect on the interstate market. Instead, they offer the conclusory argument that such diversion would routinely occur. In light of the fact that patients have their health endangered and their liberty deprived, this argument should be viewed with skepticism.

The question of Congressional power under the Commerce Clause is ultimately one of degree. *Lopez* at 566-67. Much as with the possession of a gun by the defendant in *Lopez*, the respondents' possession of medical cannabis which was cultivated purely interstate does not implicate the Commerce Clause. There is no indication that the respondents here "recently moved in interstate commerce." *Id.* Nor is there "any requirement that [their possession] of [cannabis] have any concrete tie to interstate commerce." *Id.* Further, California's laws act as a powerful disincentive for those similarly situated to respondents to place their cannabis into the stream of interstate commerce. Of course, the federal government's prohibition of sale would remain undisturbed by this Court's Commerce Clause established jurisprudence.

CONCLUSION

Unless petitioners can show that respondents' actions had a substantial affect on interstate commerce, Congress may not constitutionally prohibit respondents' intrastate possession and cultivation of medical cannabis.

California's regulatory regime casts grave doubt on the Congressional findings cited by petitioners. The class of persons who may possess cannabis is limited by a medically ascertainable standard. Even once those persons meet this standard, they remain subject to criminal sanction under California and federal law. Should they put cannabis into interstate commerce, they will be subject to federal prosecution. State prosecution will follow should respondents or those similarly situated possess or cultivate an amount of marijuana not allowed under California law. Should cannabis patients be subjected to legal scrutiny, they will have to prove medicinal use as an affirmative defense.

DATED: October 13, 2004

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BRIEF

(9)

No. 03-1454

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In The
Supreme Court of the United States

JOHN D. ASHCROFT, Attorney General, et al.,

Petitioners,

v.

ANGEL McCLARY RAICH, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF U.S. REPRESENTATIVE MARK E. SOUDER; U.S. REPRESENTATIVE CASS BALLENGER; U.S. REPRESENTATIVE DAN BURTON; U.S. REPRESENTATIVE KATHERINE HARRIS; U.S. REPRESENTATIVE ERNEST J. ISTOOK, JR.; U.S. REPRESENTATIVE JACK KINGSTON; AND U.S. REPRESENTATIVE DOUG OSE, AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the Controlled Substances Act, 21 U.S.C. 801 *et seq.*, exceeds Congress's power under the Commerce Clause as applied to the intrastate cultivation and possession of marijuana for purported personal "medicinal" use or to the distribution of marijuana without charge for such use.

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INTEREST OF AMICI AND SUMMARY OF ARGUMENT[1]

Amici are Members of the U.S. House of Representatives, each of whom has taken a strong interest in drug and narcotics policy. Representative Mark E. Souder is Co-Chair of the Speaker's Task Force For a Drug-Free America ("Speaker's Task Force"), and Chairman of the Subcommittee on Criminal Justice, Drug Policy and Human Resources (Government Reform Committee), which has oversight over all aspects of federal narcotics policy. Representative Cass Ballenger is a member of the Speaker's Task Force, and Chairman of the Subcommittee on the Western Hemisphere (International Relations Committee). Representative Dan Burton is a member of the Speaker's Task Force, and Chairman of the Subcommittee on Human Rights and Wellness. Representative Katherine Harris is a member of the Speaker's Task Force, and Vice Chair of the Subcommittee on the Western Hemisphere (International Relations Committee). Representative Ernest J. Istook, Jr., is a member of the Speaker's Task Force, and Chairman of the Subcommittee on Transportation and Treasury, and Independent Agencies (Committee on Appropriations), which has responsibility for the annual budget of the federal Office of National Drug Control Policy. Representative Jack Kingston is a member of the Speaker's Task Force, and Chairman of the Subcommittee on the Legislative Branch (Committee on

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[1] The parties have consented to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amici Curiae, the Subcommittee on Criminal Justice, Drug Policy and Human Resources (Government Reform Committee), or their counsel, made a monetary contribution to the preparation and submission of this brief.

Appropriations). Representative Doug Ose is a member of the Speaker's Task Force, and Chairman of the Subcommittee on Energy Policy, Natural Resources and Regulatory Affairs (Government Reform Committee).

Drug abuse remains the nation's most important public health problem. Each year, over 20,000 people die as a direct consequence of drug abuse, while many thousands more end up in emergency rooms due to drug-related causes. *See* Centers for Disease Control, *Deaths: Preliminary Data for 2002*, National Vital Statistics Reports, at 18 (Feb. 11, 2004); Substance Abuse & Mental Health Servs. Admin., *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1995-2002* (July 2003). The annual economic costs of drug abuse to the nation as a whole have been estimated at $143.2 billion, including $12.9 billion in health care costs (such as emergency medical care, and drug abuse treatment) and $98.5 billion in lost productivity. Executive Office of the President, Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States, 1992-1998*, at 2, 4-6 (2001).

Drug abuse is facilitated by an illegal but nationwide and flourishing market for illicit drugs. Congress and the Executive Branch have responded by attacking this commercial trade in illicit drugs, through regulation of the market backed by vigorous law enforcement. *See, e.g.*, Executive Office of the President, Office of National Drug Control Policy, *National Drug Control Strategy 2004*, at 31 (2004).

This case raises a fundamental issue: Will the Congress continue to be able to take *effective* action against the national problem of drug trafficking and abuse? In the decision here on appeal, the Ninth Circuit Court of Appeals held that

the federal government may not regulate what the court believed to be essentially "local" and "medical" illegal drug production and distribution. *Raich v. Ashcroft*, 352 F.3d 1222, 1228-34 (9th Cir. 2003). This ruling is inconsistent with this Court's Commerce Clause jurisprudence, which holds that even intrastate activities may be regulated by the federal government where, among other things, those activities have "a substantial relation to interstate commerce." *United States v. Lopez*, 514 U.S. 549, 558-60 (1995).

Marijuana is a commercial product, and its cultivation and distribution are "economic" activities, even when taking place within one state. No one state is able to take complete and effective action against this illegal market; rather, Congressional action is required. That action takes the form of a sophisticated and scientifically-based federal regulatory framework for drugs (whether medical or non-medical), including the statute at issue here – the Controlled Substances Act (CSA), 21 U.S.C. 801 *et seq.* (2004). If local marijuana production, possession and distribution are excised from that regulatory framework, the nation's ability to address the narcotics epidemic will be seriously undermined.

ARGUMENT

I. MARIJUANA, WHETHER USED FOR "MEDICAL" PURPOSES OR NOT, IS PART OF THE LARGER, COMMERCIAL MARKET FOR DRUGS, AND AS SUCH MAY BE REGULATED BY CONGRESS UNDER THE COMMERCE CLAUSE.

The Ninth Circuit's ruling is inconsistent with this Court's Commerce Clause jurisprudence. Under Article I, Section 8 of the U.S. Constitution, Congress is empowered to "regulate Commerce with foreign Nations, and among

the several States." Although the Commerce Clause speaks only to interstate commerce, Article I, Section 8 also provides that Congress shall "make all Laws which are necessary and proper for carrying into Execution the foregoing Powers." Pursuant to the "Necessary and Proper" clause, this Court has held that even intrastate activities may be regulated by the federal government where, among other things, those activities have "a substantial relation to interstate commerce." *United States v. Lopez*, 514 U.S. 549, 558-60 (1995) ("Where economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained.").

A. Marijuana Is a Commercial Product Subject to Congressional Regulation, Even When Used For So-Called "Medical" Purposes

In the post-New Deal era, this Court has struck down acts of Congress as exceeding the scope of the Commerce Clause only where the regulated activity lacks an "economic" character. Conversely, where federal regulations are targeted at economic activity, they have been sustained. *See Lopez*, 514 U.S. at 559; *United States v. Morrison*, 529 U.S. 598, 611 (2000). The Court of Appeals erred in holding that the cultivation, possession, and distribution of marijuana for "medical" purposes are not economic activities within the scope of the Commerce Clause. *Raich v. Ashcroft*, 352 F.3d 1222, 1228 (9th Cir. 2003). First, marijuana is an economic commodity, with a large and well-defined national market. Second, as a fungible, highly portable product, marijuana grown in one state can easily find its way to other states, necessitating a national system of regulation.

1. Marijuana Is an Inherently Commercial Product, With a Substantial National Market

Like all drugs, marijuana is an essentially commercial product. The fact that it may be used for alleged medical purposes certainly does not remove it from "commerce"; on the contrary, there are few commercial markets larger than that for "medical" products. In 2002, Americans spent over $1.3 trillion on personal healthcare and healthcare products; of that amount, $162.4 billion were spent on (legitimate) prescription drugs. Paulette C. Morgan, Congressional Research Service, *Health Care Spending: Past Trends and Projections*, Order Code RL31094, at CRS-1, -2 (2004).

As an illegal drug, marijuana is part of an equally commercial – albeit illegitimate – market. It is estimated that in 1998, Americans spent approximately $66 billion on illegal drugs, including $11 billion on marijuana alone. Executive Office of the President, Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988-1998*, at 1 (2000).[2] Marijuana is, in fact, the most widely used illegal drug in the United States; of the nearly 20 million current drug users in this country, approximately 14.6 million (75 percent) are using marijuana. Substance Abuse & Mental Health Servs. Admin., *2002 National Survey on Drug Use and Health* (2003).

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[2] The billions of dollars in drug proceeds produced here in the U.S. (including those from marijuana trafficking) have also spawned a massive money laundering industry, which uses our transportation and financial services networks to smuggle funds out of the country. *See* National Drug Intelligence Center, U.S. Dept. of Justice, *National Drug Threat Assessment 2004*, at 97-99.

The fact that some medical marijuana is ostensibly distributed free of charge or on a "non-profit" basis does not make this commodity any less "economic." The drug retains its value and its potential for sale, even when it is distributed for free and kept for ostensibly "medical" use. A bottle of the powerful opiate OxyContin, for example, does not lose its commercial potential while it sits in a patient's medicine cabinet.

Moreover, even "free" distribution can be economically motivated. Many companies provide certain goods or services free of charge to customers, often to build their reputations and market share; drug dealers have also been known to build their client base by providing "free samples" to prospective users. *See, e.g.*, Executive Office of the President, Office of National Drug Control Policy, *Pulse Check: Trends in Drug Abuse*, at 66 (2004) ("Some dealers distribute free drugs to 'testers' early in the morning, and then count on word-of-mouth to bring them more buyers throughout the day based on the quality or purity of the drug."). As the California court of appeals noted in 1998, permitting "non-profit" sales would allow businesses to use marijuana as an enticement to customers for other services. *People ex rel. Lungren v. Peron*, 59 Cal. App. 4th 1383, 1392-3, 70 Cal. Rptr. 2d 20, 27 (Cal. Ct. App. 1997).

2. Marijuana Is a Fungible, Portable Commodity That Can Easily Move From State to State

Marijuana is a highly fungible and portable product. As Judge Beam noted in his dissent in the opinion below, marijuana is a fungible, transferable, and therefore fundamentally economic product – even if a particular amount of marijuana has not actually been exchanged for

cash. *Raich*, 352 F.3d at 1242 ("While it is clear that plaintiffs did not propose to sell or share their marijuana with others similarly situated (or even not similarly situated), they *could*.") (emphasis in original).

Not only is marijuana a fungible product, it is extremely difficult to trace back to its source; there is currently no operational "marijuana signature" (source identification) program, as there is for cocaine and heroin. *See* National Drug Intelligence Center, U.S. Dept. of Justice, *National Drug Threat Assessment 2004*, at 48. This makes proof that the drug actually moved through interstate commerce extremely difficult, and overly burdensome to effective regulation – which is why Congress dispensed with this requirement when it enacted the CSA. *See United States v. Lopez*, 459 F.2d 949, 953 (5th Cir. 1972).

3. Effective Regulation of Marijuana Requires Federal Control of all Aspects of the Market, Including Initial Production and Distribution

As a valuable, fungible, portable, and untraceable product, marijuana presents significant challenges that can only be completely met by federal regulation. The individual states cannot adequately control marijuana trafficking. We live in a national, not a state or regional, market; if one state permits marijuana production to flourish within its borders, that production will quickly spill over into neighboring states. Stopping the flow would require each state to set up its own customs controls at its border, a solution that would be highly burdensome to the national economy, and likely to be ineffective. *See, e.g.*, Executive Office of the President, Office of National Drug

Control Policy, *2002 Final Report on the 1998 National Drug Control Strategy: Performance Measures of Effectiveness*, at 24-25 (2002) (reporting that, despite efforts of federal border and interdiction authorities, 94 percent of heroin, and 69 percent of cocaine targeted for the U.S. market entered the country).

The solution is provided by federal enforcement of the CSA. Unlike individual state regulators, the federal government can reach activity in every state. This Court has previously upheld, as valid enactments under the Commerce Clause, federal regulations of intrastate activities that affect more than one state. *See, e.g., Hodel v. Virginia Surface Mining and Reclamation Ass'n*, 452 U.S. 264, 282 (1981) (upholding environmental regulations). The CSA should be upheld on these grounds as well. *See Lopez*, 514 U.S. at 574 (Kennedy, J., concurring) ("Congress can regulate in the commercial sphere on the assumption that we have a single market and a unified purpose to build a stable national economy.").

B. Congress Has Created a Carefully Calibrated Regulatory Scheme for National Drug Markets (Including the Marijuana Market), Which Requires Effective Enforcement Even on the Local Scale

Congressional narcotics statutes are designed to deal with the local, national, and even international aspects of this enormous, complex drug market. As this Court has noted, a regulation of apparently local activity may be upheld as "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Lopez*, 514 U.S. at 561. Examples of such regulatory

frameworks upheld by this Court include price controls and quotas for wheat production, *Wickard v. Filburn*, 317 U.S. 111, 128-29 (1942); grain storage regulations, *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947); civil rights regulations of the public accommodations industry, *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 261 (1964); prohibitions on "loan sharking," *Perez v. United States*, 402 U.S. 146, 156 (1971); national wage and salary restrictions, *Fry v. United States*, 421 U.S. 542, 547-48 (1975); and environmental restrictions on coal mining, *Hodel*, 452 U.S. at 283.

Congressional regulation of narcotic drugs falls into this category as well. To regulate the frequently intersecting legal and illegal drug markets, Congress has established a finely calibrated regulatory system over the course of nearly a century. That system provides for regulations of how drugs are tested, approved, and marketed as medicines; and enforcement against those who refuse to comply with the regulations.

1. Congressional Regulation of the Drug Testing, Approval, and Marketing Process

Congress began establishing the modern-day system of medical drug regulation in 1906, with the passage of the original Pure Food and Drug Act. Prior to that Act, America "was mired in near medicinal anarchy." *See* Andrea Barthwell, M.D., *Don't Fall For Pot-Smoking Con*, Hartford Courant, Apr. 30, 2004, *available in* http://reform.house.gov/CJDPHR/Hearings/EventSingle.aspx?EventID=975. Traveling salesmen hawked "miracle medicines" that rarely actually cured anything; instead, they made patients feel better through the use of alcohol or opiates. *Id.*

This was the age of "patent medicines" which were heavily marketed and advertised with false claims as to their contents and efficacy. *See* Philip J. Hilts, *Protecting America's Health: The FDA, Business, and One Hundred Years of Regulation*, 25-30 (2003).

The 1906 Act created the agency that later came to be known as the U.S. Food and Drug Administration (FDA). *See* Hilts, *supra* at 74. The 1906 Act was superseded by the Food, Drug and Cosmetic Act (FDCA, 21 U.S.C. 301, *et seq.*) in 1938, which, for the first time, forced pharmaceutical companies to test their drugs for safety and efficacy, under the regulation of the FDA. *See* Hilts, *supra* at 95. The drug approval process under the FDCA requires rigorous scientific proof, careful review by the FDA's scientific staff, and the assurance that drugs will be marketed only for the specifically approved indications. *See Marijuana and Medicine: The Need for a Science-Based Approach, Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform*, 108th Cong , 2d Sess. (Apr. 1, 2004) (statement of Robert J. Meyer, M.D., Director, Office of Drug Evaluation II, Center for Drug Evaluation & Research, U.S. Food & Drug Admin.), at 2-7.

These Congressional actions are largely responsible for creating the modern market in safe, effective medicines. One historian argues that after the passage of the FDCA, a "revolution in medicine took place . . . [T]he pharmaceutical industry went from a handful of chemical companies with no interest in research and no medical staffs to a huge machine that discovered, developed, and marketed drugs of real use in treating disease." *Id.* Indeed, "rather than being merely a bureaucratic imposition on scientific progress, the FDA was arguably the co-inventor

of the clinical trial process . . . This is the process on which modern medicine founds most of its claims." Todd Seavey, *Regulation for Dummies: Is the FDA Necessary?*, Reason, Apr. 2004, at printed page 4.

2. Enforcement of Congressional Drug Regulations

Within a decade after passing the Pure Food and Drug Act, Congress passed the first federal drug enforcement law, the Harrison Narcotics Act, in 1914.[3] In 1970, Congress undertook a thorough revision of the federal narcotics laws, replacing them with the Controlled Substances Act (CSA), 21 U.S.C. 801 *et seq.* Although drafted in the form of a criminal statute, the CSA "concerns an obviously economic activity," *United States v. Genao*, 79 F.3d 1333, 1337 (2d Cir. 1996), namely the black market in illegal (or illegally diverted) drugs. Many of the CSA's provisions govern the registration, labeling and packaging, production quotas, and record-keeping of those wishing to manufacture, distribute or dispense controlled substances. 21 U.S.C. 822-827 (2004). It is the "enforcement" side of the regulatory framework initially established by the FDCA.

Without effective law enforcement by DEA and similar agencies, it would be impossible for Congress to ensure that only safe and effective drugs are available to the public, and that those drugs are not diverted to the illegal black market. The FDA is not, by itself, capable of effectively carrying out

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[3] The Harrison Act and other early federal narcotics enforcement statutes were based on Congress' revenue powers. *See* Charles Doyle, Congressional Research Service, *Drug Smuggling, Drug Dealing and Drug Abuse: Background and Overview of the Sanctions Under the Federal Controlled Substances Act and Related Statutes*, Order Code 97-141 A, at CRS-1 and -2 (2003).

this enforcement role; instead, it relies on enforcement of the CSA by the DEA and other federal law enforcement agencies to defend the federal government's regulation of drugs. As a law enforcement agency, "DEA has the authority, expertise, and resources to interdict the illegal use of controlled substances." *See* Letter from Patrick Ronan, Assistant Commissioner for Legislation, U.S. Food and Drug Admin., to Rep. Mark E. Souder (July 1, 2004), at 3. Moreover, the CSA, as a statute primarily directed at criminal enforcement, is the more appropriate statute for enforcement actions, providing "greater penalties and requir[ing] proof of far fewer elements to establish a violation." *Id.*

Taken together, the FDCA and the CSA represent "a powerful 'social contract for drug use,' which established that potentially addictive (and abused) drugs would be available under a physician's prescription and only to treat illnesses other than addiction. . . . This approach to potentially abused medicines is now the standard throughout the world. It has served Americans admirably for most of the 20th century, separating medical from non-medical uses, labeling the contents of medicines, and subjecting medicines to scientific review for safety and efficacy." Robert L. DuPont, *Examining the Debate on the Use of Medical Marijuana*, 111 Proceedings of the Ass'n of American Physicians 166, 167 (Mar./Apr. 1999).[4]

[4] The fluid, global nature of the illicit drug market demands not simply a national strategy, but an international one. To that end, Congress has ratified a number of international narcotics treaties obligating signatory countries to take effective steps to control potentially dangerous drugs. *See, e.g.*, Multilateral Single Convention on Narcotic Drugs, Mar. 30, 1961, 18 U.S.T. 1407, T.I.A.S. 6298; Multilateral Amendment of the Single Convention on Narcotic Drugs, Mar. 25,

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3. Federal Drug Regulation and Marijuana

The history of marijuana in this country illustrates the efficacy of federal drug regulations – and the necessity of their full enforcement. Before the era of modern science, marijuana, like alcohol and tobacco, was used as a "folk remedy" for numerous ailments over the centuries. *See* DuPont, *supra* at 167. In the 19th century, marijuana was marketed as a medicine in the form of "tinctures, extracts, and elixirs," as a remedy for "asthma, bronchitis, migraine headaches, depression, gonorrhea, uterine hemorrhage, and dysmenorrhea." Andrea Barthwell, Deputy Director, Executive Office of the President, Office of National Drug Control Policy, *Marijuana as Medicine?*, Testimony before the New England Governors' Summit on Drug Use, Oct. 8, 2003. Quality controls were virtually non-existent. *Id.*

In the modern era, however, botanical marijuana has never been able to pass the strict scientific standards adopted by Congress; as a result, it has never been approved by the FDA as a safe and effective drug. *See* Response of Amit K. Sachdev, Associate Commissioner for Legislation, U.S. Food and Drug Admin., to Rep. Mark E. Souder, Sept. 25, 2003, at 1. This is because marijuana is fundamentally bad for human health. *See, e.g.*, *Marijuana and Medicine: The Need for a Science-Based Approach,*

1972, 26 U.S.T. 1439, T.I.A.S. 8118; Multilateral Convention on Narcotic Drugs: Psychotropic Substances, Feb. 21, 1971, 32 U.S.T. 543, T.I.A.S. 9725. Among other things, the 1961 Treaty requires signatories (including the U.S.) to establish a single national agency to license and control all supplies of marijuana for medical or research purposes. *See* 1961 Treaty, art. 23, 28; *see also* International Narcotics Control Board, United Nations, *Report of the International Narcotics Control Board for 2003*, at 24 (reminding signatory countries that the 1961 Treaty requires the creation of a "national cannabis agency").

Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform, 108th Cong., 2d Sess. (Apr. 1, 2004) (statement of Nora Volkow, Director, National Institute on Drug Abuse) (detailing research into negative impacts of marijuana use on the human body, and noting that the drug is addictive); Eric A. Voth, *A Peek into Pandora's Box: The Medical Excuse Marijuana Controversy*, 22 Journal of Addictive Diseases 27, 36-38 (2003) (listing negative health effects of marijuana, including brain damage, lung damage, and heart disease).

While some research does suggest that certain components of marijuana, most notably THC, may be useful to treat certain conditions, the Director of NIDA also recently testified that "there is greater promise in purifying the active constituents of marijuana and developing alternate delivery systems, such as inhalers, rather than studying smoked marijuana." *See* Volkow Statement, at 6. In fact, the FDA has already approved pure THC in pill form (called dronabinol, or "Marinol") for some indications. *See* Eric A. Voth and Richard A. Schwartz, *Medicinal Applications of Delta-9-Tetrahydrocannabinol and Marijuana*, 126 Annals of Internal Medicine 791, 791-4 (1997). Contrary to the claims made by some pro-marijuana activists, the federal government permits and supports research into the therapeutic potential of marijuana and its components. *See* Volkow Statement, at 6-9. Pharmaceutical companies are also actively developing new treatments made from marijuana. *See, e.g., Researcher working on medical patch to deliver marijuana-like chemicals*, Aug. 20, 2003, Assoc. Press State & Local Wire, *available in* LEXIS/NEXIS (describing efforts to create a medical treatment delivering THC through the skin); Eric Bailey, *British Firm Holds Hope for Users of Medical Pot*, Los Angeles Times, Feb. 1,

2004, at B1 (describing experimental marijuana derivative known as Sativex). In short, federal regulation of marijuana is serving the interest of public health.

Through state medical marijuana laws and lawsuits such as this one, however, pro-marijuana activists are seeking to do an end-run around these important regulatory safeguards. According to the FDA, state laws purporting to legalize medical marijuana "are inconsistent with [FDA's] efforts to ensure that approved medications have undergone rigorous scientific scrutiny and FDA's approval process." *See* FDA Statement Re: Marijuana Legislation, provided to Rep. Mark E. Souder on July 7, 2004. In opposing recent legislation that would have prohibited the U.S. Department of Justice from fully enforcing marijuana laws in states purporting to legalize the drug's "medicinal" use, the FDA further stated that "DEA is the Federal agency with primary jurisdiction regarding enforcement actions relating to the sale or distribution of marijuana. FDA will continue to cooperate with DEA in these actions. . . . We reiterate that any legislation that would prevent the Department of Justice or the DEA from enforcing the CSA with respect to marijuana either generally or in specified States would not serve the interests of public health." *Id.*

C. Exempting So-Called "Medical" Marijuana From Federal Drug Regulations Would Seriously Undermine Their Effectiveness

In its opinion below, the Ninth Circuit refused to look at the problem of marijuana trafficking as a whole, or the impact that local production, possession, and distribution have on the drug trade. Instead, the court narrowed its focus to "a *separate and distinct class of activities:* the

intrastate, noncommercial cultivation and possession of cannabis for personal medical purposes." *Raich*, 352 F.3d at 1228 (emphasis in original). By examining this "class of activities" in isolation from the overall marijuana trade, the court failed to see the effects that it might have on drug trafficking and law enforcement. The Ninth Circuit's error illustrates why this Court has warned against too narrow a focus on individual cases when examining a general regulatory statute. *See Lopez*, 514 U.S. at 558 ("where a general regulatory statute bears a substantial relation to commerce, the de minimum character of individual instances arising under that statute is of no consequence") (quoting *Maryland v. Wirtz*, 392 U.S. 183, 197 n. 27 (1968)) (italics and internal quote marks omitted). Individual courts can often underestimate or even fail to recognize what motivated Congressional action – namely, the importance of seemingly local phenomena to a national problem.

As reflected in its detailed findings in the CSA, Congress understood that to be effective, enforcement of drug regulations needs to reach all levels of the drug trade – including the initial production of the drug, and its "local" possession and distribution.[5] This policy is based on

[5] "The Congress makes the following findings and declarations:

. . .

(3) A major portion of the traffic in controlled substances flows through interstate and foreign commerce. Incidents of the traffic which are not an integral part of the interstate or foreign flow, such as manufacture, local distribution, and possession, nonetheless have a substantial and direct effect upon interstate commerce because –

(A) after manufacture, many controlled substances are transported in interstate commerce,

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the fact that often the most effective drug enforcement is that which goes to the initial source of the narcotics. As this Court has held, the Commerce Clause power "permits Congress to attack an evil directly at its source, provided the evil bears a substantial relationship to interstate commerce." *North American Co. v. Securities & Exchange Comm'n*, 327 U.S. 686, 705 (1946).

Permitting even the limited marijuana cultivation and distribution allegedly at issue in this case would undermine drug regulation by (1) giving drug traffickers a new strategy to evade arrest; (2) creating geographic "safe havens" for drug dealers to base their operations; (3) increasing the risk of diversion from "medical" use to purely recreational trafficking; (4) increasing the supply and lowering the price of marijuana; and (5) potentially

(B) controlled substances distributed locally usually have been transported in interstate commerce immediately before their distribution, and

(C) controlled substances possessed commonly flow through interstate commerce immediately prior to such possession.

(4) Local distribution and possession of controlled substances contribute to swelling the interstate traffic in such substances.

(5) Controlled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate. Thus, it is not feasible to distinguish, in terms of controls, between controlled substances manufactured and distributed interstate and controlled substances manufactured and distributed intrastate.

(6) Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic."

21 U.S.C. Sec. 801 (2004).

increasing the demand for the drug through reduced public perception of marijuana's harms. These practical considerations must be taken into account when evaluating Congress' power to deal with the narcotics trade. *See id.* ("And in using this great power, Congress is not bound by technical legal conceptions. Commerce itself is an intensely practical power. . . . To deal with it effectively, Congress must be able to act in terms of economic and financial realities.").

1. Creating a "Medical" Loophole for Marijuana Cultivation, Possession, and Distribution Would Give Drug Traffickers a New Strategem to Evade Arrest and Punishment

State medical marijuana laws undermine effective law enforcement, as drug traffickers can simply assert that their products are "medicinal" – forcing law enforcement authorities to prove otherwise. There is mounting evidence that current state medical marijuana laws are already being used as a cover for large-scale drug production and trafficking. In Oregon, for example, police discovered underground marijuana greenhouses with more than 3,500 plants, with room for 5,000 to 7,000 plants; the owners held state "medical marijuana cards" entitling them to possess the drug. *See* Beth Quinn, *Southern Oregon Police Raids Find 3,500 Marijuana Plants*, Portland Oregonian, Dec. 13, 2003, at C01. In Denver, Colorado, federal agents seized 800 marijuana plants from 3 homeowners, 2 of whom had state authorization to grow "medical" marijuana. Kirk Mitchell, *Feds Seize 800 Pot Plants*, Denver Post, June 3, 2004, at B-01. And just last month, the California Highway Patrol discovered a massive clandestine marijuana growing operation – with almost 2,000 plants

worth millions of dollars; medical marijuana activists, however, claimed that the marijuana was for "medical" purposes and was legal under Oakland city laws. Paul T. Rosynsky, *Big dispute in city pot bust*, Alameda Times Star, July 1, 2004, *available in* LEXIS/NEXIS. According to the U.S. Department of Justice, outlaw motorcycle gangs have applied for medical marijuana "caregiver" status, in an effort to legitimize their marijuana grow operations. *See* Letter from Robert F. Diegelman, Acting Assistant Attorney General for Administration, U.S. Dept. of Justice, to Paul Jones, Director, Justice Issues, General Accounting Office, dated Sept. 27, 2002, *reprinted in* General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, Report No. GAO-03-189, at 57 (2002). In Nevada, a convicted drug dealer obtained a state "medical marijuana" registration card (purportedly to treat his "bipolar" mental condition), and began growing the drug and "sell[ing] or giv[ing]" it to "about 20 other medical marijuana patients through his enterprise, Primary Caregivers and Consultants." Ed Vogel, *Medical Marijuana: Working to smoke out abusers*, Las Vegas Review-Journal, Apr. 12, 2004, at 1B.

Exemptions for "small" amounts of marijuana can also be a boon for drug traffickers. Three ounces of marijuana, for example, can make anywhere from 90 to over 250 marijuana cigarettes, or "joints" – enough to supply a so-called "medical marijuana user" for a month. *See* Dan Kulin, *Number of joints possible with 3 ounces of pot debated: Question 9 argument becomes food for commercial*, Las Vegas Sun, Oct. 15, 2002, 2002 WL 101210627. Where small amounts are presumed to be beyond the reach of the law, drug dealers will simply distribute drugs in those amounts so as to escape arrest. *See, e.g., Costa*

Rica: Review, Americas Review World of Information, Sept. 23, 2002, 2002 WL 100885937 (since Costa Ricans are allowed to possess small amounts of drugs, it makes it very difficult to stop dealing in drugs like crack cocaine).

2. Allowing Individual States To Immunize Marijuana Possession From Federal Regulation Would Create Geographic "Safe Havens" For Drug Traffickers

If certain states are permitted to simply "opt out" of federal drug regulation, they will quickly become a haven for drug traffickers. Drug trafficking organizations typically seek out venues where the drug laws, and/or the enforcement of those laws, are weaker; the drugs they manufacture or import in those areas can then be smuggled into areas where drug enforcement is more stringent. This has been especially obvious in the international arena. For example, when Congress passed stricter laws against the diversion of the precursor chemicals for methamphetamine production (such as pseudoephedrine), drug traffickers turned to Canada (where precursor chemical regulation was much weaker) as their source of supply. *See* Office of International Intelligence, U.S. Drug Enforcement Administration, and Criminal Intelligence Directorate, Royal Canadian Mounted Police, *Chemical Diversion and Synthetic Drug Manufacture*, at printed pages 1, 8. Similarly, lax Canadian laws and enforcement against marijuana growing have made the province of British Columbia a center of high-potency marijuana production. *See* Quentin Hardy, *Inside Dope*, Forbes, Nov. 10, 2003, at 146 (noting that in British Columbia only one-fifth of marijuana busts result in incarceration and the average sentence is only four months). This high-potency

marijuana is being smuggled into the U.S. *See* U.S. Department of State, *International Narcotics Control Strategy Report, 2003* (2004).

In Europe, lenient drug policies have made the Netherlands a haven for drug smuggling. *See, e.g.*, Justin Sparks, *Dutch Law Could Unleash Cocaine Flood In Britain*, London Times, Feb. 1, 2004, at 24; Ciarin McGuigan, *Mule be sorry; Dutch decision to 'let off' drug smugglers could lead to growth in trafficking here*, Belfast Telegraph Newspapers – Sunday Life, Mar. 14, 2004, *available in* LEXIS/NEXIS (Dutch policy of releasing drug smugglers at its airports carrying "normal" amounts of illegal drugs has sparked neighbors' fears that the Netherlands will become the preferred European Union gateway for narcotics). *See also* Anthony Browne, *Dutch drug café ban puts British noses out of joint*, London Times, Oct. 25, 2003, Overseas news section, at 5 (reporting on Dutch government's consideration of plan to forbid foreigners from accessing legal marijuana shops in the Netherlands, in part to stop cross-border trafficking by German drug dealers who purchase marijuana in the Netherlands and then drive it to Germany).

This problem is exacerbated by the fact that in states and localities that have attempted to legalize marijuana, state and local officials (facing local political pressures) are increasingly hostile to federal drug policies. For example, one California sheriff recently stated that he would, if necessary, actually remove seized marijuana from his department's evidence locker and give it to a friend in medical need. *See* Josh Richman, *Cops say feds' focus 'misplaced'*, Oakland Tribune, May 25, 2003, 2003 WL 8915341. According to the U.S. Department of Justice,

state officials are often refusing to prosecute obvious cases of drug dealing out of deference to state "medical marijuana" laws, and in one instance a local district attorney even ordered a county detective to arrest a DEA agent if the agent seized marijuana plants purportedly belonging to a "patient". *See* Diegelman Letter, *supra* at 56.

Furthermore, if drug production is permitted to take root in a community, that community can quickly become economically dependent on the drug – putting additional pressure on local governments to turn a blind eye to the problem. *See* Hardy, *supra* (reporting that marijuana has become Canada's most valuable agricultural crop, with even the legitimate British Columbian economy increasingly dependent on the profits from it). In fact, many so-called "medical" marijuana sellers now openly operate as businesses in California (which has the most permissive medical marijuana law). In Rosewood, California, a store sells strains of marijuana known as "Romulan," "White Rhino," "Acapulco Gold," and "Placer Gold" for $200-$320 per ounce, reportedly with the tacit approval of the local chief of police. *See* Art Campos and Jocelyn Wiener, *Store for medical pot opens in Roseville*, Sacramento Bee, Jan. 31, 2004, at A1. In Oakland, California, a dozen "cafes" selling purported medicinal marijuana (at least one owner claiming to serve 7,000 "patients") were in operation by the end of 2003, earning it the nickname "Oaksterdam"; in 2004, the city attempted to limit the number of stores by issuing marijuana "business permits" (in return for a $20,000 annual fee). *See* Jean Marbella, *Marijuana 'du jour' in Oakland*, Baltimore Sun, Nov. 28, 2003, at 1A; Laura Counts, *Medical marijuana merchant defies Oakland order to close*, Alameda Times-Star, June 2, 2004, *available in* LEXIS/NEXIS.

Nor can state medical boards in such states be relied on to provide effective regulation. As one commentator has observed, medical marijuana initiatives "have created serious regulatory dilemmas for state regulatory boards." Voth, *A Peek into Pandora's Box* at 27. Despite their mission to oversee the practice of medicine in their respective states, many of these boards disavow any responsibility to determine whether drugs are safe or effective. *See Marijuana and Medicine: The Need for a Science-Based Approach, Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform*, 108th Cong., 2d Sess. (Apr. 1, 2004) (statement of James D. Scott, Member and Past Chair, Oregon Board of Medical Examiners), at 2, ("No one representing the [Board] is prepared to give any testimony regarding the scientific or medicinal value of marijuana, or any sociopolitical issues regarding marijuana. These issues are beyond our jurisdiction."); Letter from Joan M. Jerzak, Chief of Enforcement, Medical Board of California, to Rep. Mark E. Souder, May 11, 2004, at 1, 2 ("The Board does not establish 'procedures' which physicians must follow, nor does it take a position with regard to specific medications. . . . [I]t is not for the Board to determine which medical conditions may be appropriately treated with marijuana.").

3. Legalizing "Medical" Marijuana Will Increase the Chances of Diversion to Purely Recreational Use

By increasing the amount of marijuana, and the number of "legitimate" uses for it, state medical marijuana laws increase the chance that the drug will be diverted to purely recreational uses. The more legally available any

drug is the more indications it is approved for, and the greater the quantities of the drug in legitimate channels, the higher the rate of illegal diversion, trafficking and abuse will be. *See* Responses of Thomas W. Raffanello, Special Agent in Charge, Miami Division, Drug Enforcement Administration, to Questions from Rep. Mark E. Souder, May 24, 2004, at 2; Letter from Amit K. Sachdev, Associate Commissioner for Legislation, U.S. Food and Drug Admin., to Rep. Mark E. Souder, Apr. 26, 2004, at 2. The diversion of legal (but controlled) medical drugs into illegal uses is widespread, rivaling the market for strictly illegal drugs. For example, nationwide in 1993, people spent an estimated $25 billion on prescription drugs in the illegal market, compared with $31 billion on cocaine, including crack. *See* National Drug Strategy Network, *Prescription Drug Abuse Rivals Illicit Drug Abuse, Some See Double Standard in Law Enforcement*, New Briefs – Drug Use Trends (Oct. 1996). Abuse of legal prescription drugs, such as the opiate OxyContin, is on the rise; by 2001, prescription pain killers were second only to marijuana as the most abused category of drug. *See* National Survey on Drug Use and Health, *Nonmedical Use of Prescription Pain Relievers*, at 2 (2004).

Once a drug can be legally obtained, drug dealers and addicts have an increased number of avenues to obtain it – including prescription fraud (forging prescriptions; visiting multiple doctors to obtain prescriptions, often called "doctor shopping"; and altering prescriptions to increase the quantity); and outright theft or robbery from pharmacies (often performed by pharmacy workers themselves). *See* Julie Wartell and Nancy G. La Vigne, Office of Community Oriented Policing Services, U.S. Dept. of Justice, *Prescription Fraud* (2004), at 2-3. Those obtaining these drugs via fraud can, and do, ship them for profit to other

states. *See, e.g.*, Drug Enforcement Administration, *OxyContin: Pharmaceutical Diversion*, at printed page 5 (2002) (reporting DEA investigation into individual who took advantage of a severe medical condition to obtain legitimate prescriptions for OxyContin and other oxycodones from physicians in Arizona and California; he then shipped the pills – approximately 8,000 to 9,000 over the course of a year – via FedEx to another individual in Maryland for distribution).

The risk of "medical" marijuana being diverted is heightened by the fact that certain doctors have been consistently expanding their list of marijuana-treatable "conditions." One doctor, Frank H. Lucido, reports writing medical marijuana recommendations for 348 patients over a six-month period in 2002, for a wide range of conditions, including headaches, chronic anxiety, depression, insomnia, post-traumatic stress disorder, asthma, bipolar disorder, attention deficit disorder, vertigo, tinnitus, restless leg syndrome, phantom limb pain, and obsessive compulsive disorder. Frank H. Lucido and Mariavittoria Mangini, *Implementation of the Compassionate Use Act in a Family Medical Practice: Seven Years' Clinical Practice*, O'Shaughnessy's Journal of the California Cannabis Research Medical Group, Spring 2004, at 3. Claudia Jensen, a California pediatrician, has stated that she has recommended marijuana to teenagers with attention deficit disorder, despite acknowledging that "the science is lacking to justify some of her unorthodox uses." Daniel Costello, *Unorthodox uses for medical marijuana*, Los Angeles Times, Feb. 23, 2004, at F3; *see also Marijuana and Medicine: The Need for a Science-Based Approach, Hearing Before the Subcomm. on Criminal Justice, Drug Policy & Human Resources of the House Comm. on Government Reform*, 108th Cong., 2d Sess. (Apr. 1, 2004)

(statement of Claudia Jensen, M.D.), at 7-9. These cases are not isolated incidents. A 2003 study of AIDS patients using marijuana showed that less than one third smoked the drug even to relieve pain; 57 percent smoked to relieve anxiety or depression, while 33 percent admitted they smoked for "recreational" reasons. Sara Zaske, *Study: Many HIV patients use pot for mental health*, San Francisco Examiner, June 9, 2003, *available in* http://reform.house.gov/CJDPHR/Hearings/EventSingle.aspx?EventID=975. In Oregon, of the 10,196 patients registered with the state's medical marijuana program, only 335 were listed as suffering from cancer; only 221 with HIV/AIDS; only 198 with glaucoma; and only 438 with cachexia; by contrast, 8,711 patients listed "pain" as their reason for taking the drug. *See* Oregon Department of Human Services, *Oregon Medical Marijuana Program Statistics* (July 1, 2004).

Other pro-marijuana doctors are, moreover, also writing very large numbers of "recommendations" for marijuana. According to one estimate, as of spring 2004, 100,000 marijuana recommendations had been issued in California, almost half written by only 12 physicians in California – all associated with a group known as the California Cannabis Research Medical Group. Fred Gardner, *Encouraged by 9th Circuit's Conant Ruling, More California Doctors Approve Cannabis Use*, O'Shaughnessy's Journal of the California Cannabis Research Medical Group, Spring 2004, at 1. One doctor alone acknowledged writing approximately 8,000 such recommendations. *Id.* at 7. In Oregon, Dr. Phillip E. Leveque was recently suspended by the state medical board for writing 4,000 medical marijuana authorizations – approximately 40 percent of the total such authorizations in the state – often without conducting any physical examination or even personally meeting with his patients. *See* Kramer, Andrew, *Oregon doctor's license*

suspended for signing marijuana cards, Associated Press, Mar. 5, 2004, *available in* LEXIS/NEXIS.

4. The Aggregate Effect of Even Individual Cultivation of "Medical" Marijuana Justifies Federal Regulation

Even when marijuana never actually enters the immediate stream of commerce, it may still be regulated to prevent it from impacting the broader market. This Court has repeatedly held that Congress may look to the total, aggregate effect of many apparently small, local transactions on interstate commerce and federal regulations thereof. *See, e.g., Wickard*, 317 U.S. at 128-29 (aggregate effect of home-grown and personally consumed wheat); *Katzenbach v. McClung*, 379 U.S. 294, 301 (1964) (aggregate effect of many individual acts of racial discrimination at restaurants); *Perez*, 402 U.S. at 154-55 (aggregate effect of acts of loan sharking); *Fry*, 421 U.S. at 547 (aggregate effect of wage increases for state employees).

As was the case in *Wickard*, marijuana grown and consumed, even locally by purported "medical" users, can exert a significant effect on the traffic in the drug, by adding to the nation's marijuana supply while reducing demand on the immediate market. The result will be lower overall prices on the black market. *See Proyect v. United States*, 101 F.3d 11, 14 n. 1 (2d Cir. 1996) ("[T]he cultivation of marijuana for personal consumption most likely does substantially affect interstate commerce. This is so because 'it supplies a need of the man who grew it which would otherwise be reflected by purchases in the open market.'") (citing *Wickard*, 317 U.S. at 128); *see also* Drug Enforcement Administration, *Illegal Drug Price and Purity Report* (Apr. 2003) ("A decrease in drug price

typically indicates an increase in availability, and, conversely, a price increase usually indicates a decrease in supply."). This would undermine a key component of the federal government's anti-marijuana strategy, namely to increase the price of illicit drugs, resulting in a reduction in the demand. *See* Office of National Drug Control Policy, *National Drug Control Strategy 2004*, at 31 ("The main reason supply reduction matters to drug policy is that it makes drugs more expensive, less potent, and less available. Price, potency, and availability are significant drivers of both addicted use and casual use.").

5. Legitimizing "Medical" Use of Marijuana Will Potentially Increase the Demand For the Drug, by Reducing Public Perception of Marijuana's Harms

Repeated claims of marijuana's "medicinal" value, coupled with the apparent ratification of those claims by state medical marijuana laws, have lowered the public perception of marijuana's scientifically demonstrated harmfulness – particularly among young people. *See* Andrea Barthwell, Deputy Director, Office of National Drug Control Policy, *Marijuana Is Not Medicine*, Chicago Tribune, Feb. 17, 2004, at C19 ("Children entering drug abuse treatment routinely report that they heard that 'pot is medicine' and, therefore, believed it to be good for them."). These public perceptions can have a significant impact on marijuana usage rates. *See, e.g.*, Wilson M. Compton, et al., *Prevalence of Marijuana Use Disorders in the United States, 1991-1992 and 2001-2002*, 291 JAMA 2114, 2119 (2004) (reporting study demonstrating that decreases in the perceived risk of harmfulness and in

disapproval of marijuana use can explain the recent rise in marijuana use by young people).

D. If Congress Is Prevented From Regulating Local Production, Possession, and Distribution of Marijuana, Its Ability To Regulate Other Drugs Will Be Placed in Jeopardy

A ruling that the federal government may not regulate local production, possession, and distribution of "medical" marijuana would have far-reaching implications for the regulation of all drugs, both legal and illegal. A vast number of controlled substances may be produced in the home, including methamphetamine, GHB, and MDMA ("ecstasy"). *See* Drug Enforcement Administration, *Drug Trafficking in the United States* (2001). And virtually all drugs have at least some putative "medical" uses; for example, cocaine and heroin were long used as anaesthetics, methamphetamine as a stimulant, and for many years LSD and ecstasy were used in psychotherapy.

This scenario is not as unlikely as it may seem. In fact, many of the same proponents of medicinal marijuana have actively sought to force the approval of some of these other drugs as "medicines." *See, e.g., Grinspoon v. Drug Enforcement Admin.*, 828 F.2d 881 (1st Cir. 1987) (petition by pro-medical marijuana advocate Dr. Lester Grinspoon to remove ecstasy from Schedule I of CSA). In several foreign countries, physicians may now prescribe heroin to addicts as part of a medical practice known as "maintenance," and the same may soon be done for cocaine. *See, e.g.*, Dan Gardner, *Free junk for junkies*, Ottawa Citizen, Jan. 18, 2004, at C3; *Doctors push for cocaine prescription*, Swissinfo, June 3, 2004, *available at* http://www.swissinfo.org/sen/Swissinfo.html?siteSect=105&sid=4958011. If a

state were to attempt to approve these or any other currently controlled drugs for "medical" use, it would set up the same federal-state conflict present here.

CONCLUSION

Describing the 19th century age of "quack medicines," one historian writes that, "The market in medicines, without any regulation, was essentially the same as the only market today with no regulation – the trade in heroin, cocaine, and other drugs. The supply was unreliable, the purity suspect, the price high and variable, and the corrupted substances sometimes fatal." Hilts, *supra* at 27. Proponents of "medical" marijuana would take us full circle, "back to a time before the passage of the Pure Food and Drug Act." Barthwell, *Marijuana as Medicine?* Through its power to regulate the interstate commerce in medical drugs, Congress has the responsibility to protect the American public from such a foolish step backwards. That power, and that responsibility, are fully consistent with the Constitution and should not be denied. The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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